**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

FONDREN ORTHOPEDIC GP LLP
7401 SOUTH MAIN STREET
HOUSTON TEXAS 77030

**Respondent Name**
AMERICAN HOME ASSURANCE CO

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-13-2115-01

**MFDR Date Received**
April 22, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary taken from the Request for Reconsideration letter:** "Claim was processed and PT code Q4038 was processed and underpaid. This is a DME/supplies charge according to Texas work comp fee schedule this should be paid at 125% of the Medicare allowable. The Medicare allowable for this code is $38.90. We are respectfully requesting you reprocess and pay the additional amount owed of $19.37 as we under billed to begin with."

**Amount in Dispute:** $19.37

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Please note that the procedure was previously reimbursed at fair and reasonable in accordance with the DWC fee guidelines. See the attached initial and reconsideration EOBs."

**Response Submitted by:** Hoffman Kelley

**SUMMARY OF FINDINGS**

| Date of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 7, 2012 | Q4038 | $19.37 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 5375 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
   - 5080 – Reimbursed to fair and reasonable

**Findings**

1. 28 Texas Administrative Code §134.203 states in pertinent part, "(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."
   - The requestor seeks additional reimbursement HCPCS code Q4038 defined as "Cast supplies, short leg cast, adult (11 years +), fiberglass."
   - 28 Texas Administrative Code §134.203 does not address the reimbursement of HCPCs code Q4038, therefore subject to the provisions of §134.1.
2. 28 Texas Administrative Code §134.203 states in pertinent part, "(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."
   - Q codes are identified by Medicare as "Temporary 'Q' codes have been established for supplies used by physicians and other practitioners to create splints and casts used for reduction of fractures and dislocations..."
   - "Medicare further instructs "At that time, FIs should contact their carriers to obtain a price when they receive a claim reflecting any of the Q codes listed below. In the interim, these facilities continue to bill and be paid for casting and splinting materials as they have in the past."
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(N)(i), requires that the request shall include a position statement of the disputed issues including "(i) the requestor's reasoning for why the disputed fees should be paid or refunded."
   - Review of the submitted documentation finds that the requestor has not explained the reasons that the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(i).
6. 28 Texas Administrative Code §133.307(c)(2)(N)(ii), requires that the request shall include a position statement of the disputed issue(s) that shall include: "how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues."
   - Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307 (c)(2)(N)(ii).

7. 28 Texas Administrative Code §133.307(c)(2)(N)(iii), requires that the request shall include a position statement including "how the submitted documentation supports the requestor's position for each disputed fee issue."
    - Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(iii).
8. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:
    - The requestor did not submit a position statement for consideration in this dispute.
    - The requestor's request for reconsideration letter asserts that "Claim was processed and PT code Q4038 was processed and underpaid. This is a DME/supplies charge according to Texas work comp fee schedule this should be paid at 125% of the Medicare allowable. The Medicare allowable for this code is $38.90. We are respectfully requesting you reprocess and pay the additional amount owed of $19.37 as we under billed to begin with."
    - The requestor did not submit documentation to support that "This is a DME/supplies charge according to Texas work comp fee schedule this should be paid at 125% of the Medicare allowable. The Medicare allowable for this code is $38.90."
    - The requestor does not discuss or explain how the 125% supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
    - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
    - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
    - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

    The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | August 30, 2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.